		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044172

Facility Name: MAPLE CREST CARE CENTRE

Address: 4452 SQUAW PRAIRIE ROAD (Number) BELVIDERE (City) 61008 (Zip Code)

County: BOONE

Telephone Number: (815) 547-6377 **Fax #** (815) 547-3857

IDPA ID Number: 36-4253834

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,778	1,545	3,508	7,831	8
9	SNF/PED					9
10	ICF	13,083	7,298	1,212	21,593	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,861	8,843	4,720	29,424	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.97%

D. How many bed-hold days during this year were paid by Public Aid?
119 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 3,235

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	166,212	9,269	7,838	183,319		183,319	113	183,432			1
2	Food Purchase		102,839		102,839		102,839	(749)	102,090			2
3	Housekeeping	47,470	15,091		62,561		62,561	255	62,816			3
4	Laundry	36,024	9,192	1,070	46,286		46,286	(495)	45,791			4
5	Heat and Other Utilities			77,751	77,751		77,751		77,751			5
6	Maintenance	58,133	24,098	35,189	117,420		117,420	818	118,238			6
7	Other (specify):*			2,943	2,943		2,943		2,943			7
8	TOTAL General Services	307,839	160,489	124,791	593,119		593,119	(58)	593,061			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,202,702	50,064	102,314	1,355,080		1,355,080	14,076	1,369,156			10
10a	Therapy	71,918		13,129	85,047		85,047		85,047			10a
11	Activities	81,174	2,953	526	84,653		84,653	(121)	84,532			11
12	Social Services	27,094		7,190	34,284		34,284		34,284			12
13	Nurse Aide Training											13
14	Program Transportation			50	50		50		50			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,382,888	53,017	126,809	1,562,714		1,562,714	13,955	1,576,669			16
	C. General Administration											
17	Administrative	71,910		329,195	401,105		401,105	(324,080)	77,025			17
18	Directors Fees											18
19	Professional Services			112,168	112,168		112,168	2,133	114,301			19
20	Dues, Fees, Subscriptions & Promotions			28,199	28,199		28,199	(17,910)	10,289			20
21	Clerical & General Office Expenses	64,488	25,091	14,418	103,997		103,997	85,166	189,163			21
22	Employee Benefits & Payroll Taxes			314,242	314,242		314,242		314,242			22
23	Inservice Training & Education			5,877	5,877		5,877		5,877			23
24	Travel and Seminar							4,512	4,512			24
25	Other Admin. Staff Transportation			2,776	2,776		2,776		2,776			25
26	Insurance-Prop.Liab.Malpractice			105,112	105,112		105,112	2,628	107,740			26
27	Other (specify):*			24,000	24,000		24,000	(24,000)				27
28	TOTAL General Administration	136,398	25,091	935,987	1,097,476		1,097,476	(271,551)	825,925			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,827,125	238,597	1,187,587	3,253,309		3,253,309	(257,654)	2,995,655			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MAPLE CREST CARE CENTRE #0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			68,996	68,996		68,996	(36,670)	32,326			30
31	Amortization of Pre-Op. & Org.			10,000	10,000		10,000		10,000			31
32	Interest			92,158	92,158		92,158	(9,680)	82,478			32
33	Real Estate Taxes			(4,526)	(4,526)		(4,526)		(4,526)			33
34	Rent-Facility & Grounds			59,167	59,167		59,167	8,421	67,588			34
35	Rent-Equipment & Vehicles			5,735	5,735		5,735	3,884	9,619			35
36	Other (specify):*											36
37	**TOTAL Ownership**			231,530	231,530		231,530	(34,045)	197,485			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,830	191,948	264,778		264,778		264,778			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		72,830	237,938	310,768		310,768		310,768			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,827,125	311,427	1,657,055	3,795,607		3,795,607	(291,699)	3,503,908			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(39,742)	30		9
10	Interest and Other Investment Income	(9,680)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(749)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(66)	21		18
19	Entertainment	(7,514)	20		19
20	Contributions	(2,850)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(678)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	27		24
25	Fund Raising, Advertising and Promotional	(7,605)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(754)	20		28
29	Other-Attach Schedule SEE PAGE 5A	5,804			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,834)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(203,865)	PG 6	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (203,865)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (291,699)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MAPLE CREST CARE CENTRE

ID# 0044172

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 525	6	1
2	VACATION ACCRUAL	113	1	2
3	VACATION ACCRUAL	255	3	3
4	VACATION ACCRUAL	(495)	4	4
5	VACATION ACCRUAL	293	6	5
6	VACATION ACCRUAL	8,417	10	6
7	VACATION ACCRUAL	(121)	11	7
8	VACATION ACCRUAL	(3,530)	17	8
9	VACATION ACCRUAL	347	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	5,804		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	113	0	0	0	0	0	0	0	0	0	0	113	1
2	Food Purchase	(749)	0	0	0	0	0	0	0	0	0	0	(749)	2
3	Housekeeping	255	0	0	0	0	0	0	0	0	0	0	255	3
4	Laundry	(495)	0	0	0	0	0	0	0	0	0	0	(495)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	818	0	0	0	0	0	0	0	0	0	0	818	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(58)	0	0	0	0	0	0	0	0	0	0	(58)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	8,417	5,659	0	0	0	0	0	0	0	0	0	14,076	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(121)	0	0	0	0	0	0	0	0	0	0	(121)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	8,296	5,659	0	0	0	0	0	0	0	0	0	13,955	16
	C. General Administration													
17	Administrative	(3,530)	(320,550)	0	0	0	0	0	0	0	0	0	(324,080)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(678)	2,811	0	0	0	0	0	0	0	0	0	2,133	19
20	Fees, Subscriptions & Promotions	(18,723)	813	0	0	0	0	0	0	0	0	0	(17,910)	20
21	Clerical & General Office Expenses	281	84,885	0	0	0	0	0	0	0	0	0	85,166	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,512	0	0	0	0	0	0	0	0	0	4,512	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,628	0	0	0	0	0	0	0	0	0	2,628	26
27	Other (specify):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	27
28	**TOTAL General Administration**	(46,650)	(224,901)	0	0	0	0	0	0	0	0	0	(271,551)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(38,412)	(219,242)	0	0	0	0	0	0	0	0	0	(257,654)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number MAPLE CREST CARE CENTRE **#** 0044172 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(39,742)	3,072	0	0	0	0	0	0	0	0	0	(36,670)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,680)	0	0	0	0	0	0	0	0	0	0	(9,680)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,421	0	0	0	0	0	0	0	0	0	8,421	34
35	Rent-Equipment & Vehicles	0	3,884	0	0	0	0	0	0	0	0	0	3,884	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(49,422)	15,377	0	0	0	0	0	0	0	0	0	(34,045)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,834)	(203,865)	0	0	0	0	0	0	0	0	0	(291,699)	45

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					MORTON GROVE	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES, INC.		$ 5,659	$ 5,659	1
2	V	17	ADMINISTRATIVE	329,195	MR. BELLOWS OWNS 67.5% OF THIS FACILITY		8,645	(320,550)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		2,811	2,811	3
4	V	20	DUES & SUBSCRIPTIONS		" "		813	813	4
5	V	21	CLERICAL		" "		84,885	84,885	5
6	V	24	TRAVEL		" "		4,512	4,512	6
7	V	26	INSURANCE		" "		2,628	2,628	7
8	V	30	DEPRECIATION		" "		3,072	3,072	8
9	V	34	RENT		" "		8,421	8,421	9
10	V	35	RENT-EQUIPMENT & VEH		" "		3,884	3,884	10
11	V								11
12	V								12
13	V								13
14	Total			$ 329,195			$ 125,330	$ * (203,865)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	67.5%	SEE ATTACHED	1.4	5.79	SALARY	8,645	17-7	2
3	EMANUEL BINSTOCK	MNGMT CNSLT.	ADMIN.	5%	NONE	2.4	10.00	SALARY	5,301	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,946		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847)583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	496,459	9	$ 95,479	$ 95,479	29,424	$ 5,659	1
2	17	ADMINISTRATIVE	PATIENT DAYS	496,459	9	145,864	145,864	29,424	8,645	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	496,459	9	47,431		29,424	2,811	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	496,459	9	13,714		29,424	813	4
5	21	CLERICAL	PATIENT DAYS	496,459	9	190,601		29,424	11,297	5
6	21	CLERICAL	DIRECT COST	1	1	73,588	73,588	1	73,588	6
7	24	TRAVEL	PATIENT DAYS	496,459	9	76,130		29,424	4,512	7
8	26	INSURANCE	PATIENT DAYS	496,459	9	44,347		29,424	2,628	8
9	30	DEPRECIATION	PATIENT DAYS	496,459	9	51,835		29,424	3,072	9
10	34	RENT	PATIENT DAYS	496,459	9	142,084		29,424	8,421	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	496,459	9	65,539		29,424	3,884	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 946,612	$ 314,931		$ 125,330	25

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MEMBER LOANS	X		WORKING CAPITAL	DEMAND	VARIES	150,000	200,978	DEMAND	0.0775	14,455	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	721,000	938,187	DEMAND	SEE SCH	77,703	7
8												8
9	TOTAL Facility Related						$ 871,000	$ 1,139,165			$ 92,158	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 871,000	$ 1,139,165			$ 92,158	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 48,768	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 46,974	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,794)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 30,048	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 32,780 For 99/01 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (32,780)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ (4,526)	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999	42,234	10
2000	48,238	11
2001	46,974	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAPLE CREST CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044172

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-14-100-015	NURSING HOME	$ 46,973.58	$ 46,973.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,973.58	$ 46,973.58

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 50,000
2. Number of Years Over Which it is Being Amortized: 60 MONTHS
3. Current Period Amortization: 10,000
4. Dates Incurred: 1999

Nature of Costs: LEGAL COSTS
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	653,400		$	1
2					2
3	TOTALS	653,400		$	3

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLCOVERING/BORDERS/VINYL COVERINGS			1999	17,944	2,563	7	2,563		9,494	9
10	STEEL DOORS			1999	2,337	85	27.5	85		310	10
11	SIGN, SIGN FOOTINGS AND BRICKS			1999	4,652	169	27.5	169		528	11
12	REMODEL-DINING & REC RM., OFFICES, HALLS			1999	73,951	2,691	27.5	2,691		8,630	12
13	CONDENSING UNIT FOR WALK IN FREEZER			2000	3,695	134	27.5	134		285	13
14	WATER SOFTENER UNIT			2000	10,120	368	27.5	368		782	14
15	ARCHITECTURAL DRAWINGS FOR ADDING 6 BEDS			2001	11,239	409	27.5	409		801	15
16	TWO HOT WATER HEATERS			2001	13,065	475	27.5	475		930	16
17	REMOVAL OF WATER TANKS & PIPING			2001	7,650	278	27.5	278		521	17
18	REPAIRS TO GRAVEL ROOF			2001	2,875	105	27.5	105		170	18
19	BLACKTOP PARKING LOT			2001	1,270	46	27.5	46		75	19
20	AIRCONDITIONING - REPAIRS & INSTALLATION - DINING RM.			2001	7,430	270	27.5	270		416	20
21	ASBESTOS ABATEMENT/FLOOR RENOVATION			2001	1,400	51	27.5	51		77	21
22	REPLACE WATER COIL - FOOD STORAGE AREA			2001	7,500	273	27.5	273		375	22
23	INSTALL CONTROL DAMPER IN BATHING AREA			2001	1,795	65	27.5	65		79	23
24	BOILER ROOM EXHAUST FAN			2001	1,980	72	27.5	72		87	24
25	REPLACE DAMPER ON GENERATOR			2001	1,260	46	27.5	46		52	25
26	ADDITION OF 6 BEDS-GENERAL CONSTR/WINDOWS/PAINTING			2001	103,815	3,775	27.5	3,775		4,247	26
27	EXHAUST FANS FOR KITCHEN & DISHWASHING AREA			2001	5,894	214	27.5	214		241	27
28	AIR CONDITIONING CONDENSING UNIT			2002	8,557	207	27.5	207		207	28
29	ROOF REPAIR OVER LAUNDRY RM, RMS 212 & 114, FOYER			2002	9,800	178	27.5	178		178	29
30	ROOF REPAIRS			2002	2,030	12	27.5	12		12	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 300,259	$ 12,486		$ 12,486	$	$ 28,497	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 156,158	$ 24,201	$ 12,552	$ (11,649)	3-15 YRS	$ 37,418	71
72	Current Year Purchases	61,150	32,309	4,216	(28,093)	3-15 YRS	4,216	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	24,073	3,072	3,072			3,874	74
75	TOTALS	$ 241,381	$ 59,582	$ 19,840	$ (39,742)		$ 45,508	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 541,640	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,068	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,326	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (39,742)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 74,005	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	ADDITION OF 6 BEDS	$ 5,116	92
93			93
94			94
95		$ 5,116	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: COUNTY OF BOONE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		78	02/01/99	$ 59,167			3
4	Additions	12/11/2001	6					4
5								5
6								6
7	TOTAL		84		$ 59,167 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning 02/01/99
Ending 02/01/30

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2003	$ 87,500
13.	12/31/2004	$ 91,650
14.	12/31/2005	$ 91,800

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,735 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 89,408	$		$ 89,408	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,762			3,762	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			98,778			98,778	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				58,927		58,927	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, XRAY, RENTALS, I.V. THERAPY Other (specify):	39-2					13,903		13,903	13
14	TOTAL			$		$ 191,948	$ 72,830		$ 264,778	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 751,626	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 21,924)	570,986		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,265		6
7	Other Prepaid Expenses	228		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,348,105	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	300,259		15
16	Equipment, at Historical Cost	217,306		16
17	Accumulated Depreciation (book methods)	(151,371)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	50,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(39,167)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROG.	5,116		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 382,143	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,730,248	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 217,379	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,699		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,499		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,316		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,048		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	600,945		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 970,886	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,139,165		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,139,165	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,110,051	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (379,803)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,730,248	$	48

***(See instructions.)**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (695,877)	1
2	Restatements (describe):		2
3	ROUNDING ADJUSTMENT	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (695,876)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	316,073	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 316,073	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (379,803)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,098,916	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,098,916	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	50	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 50	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,680	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,680	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	3,034	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,034	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,111,680	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	593,119	31
32	Health Care	1,562,714	32
33	General Administration	1,097,476	33
	B. Capital Expense		
34	Ownership	231,530	34
	C. Ancillary Expense		
35	Special Cost Centers	264,778	35
36	Provider Participation Fee	45,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,795,607	40
41	**Income before Income Taxes (line 30 minus line 40)****	316,073	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 316,073	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,689	2,689	$ 90,908	$ 33.81	1
2	Assistant Director of Nursing	831	863	20,745	24.04	2
3	Registered Nurses	8,201	8,515	187,710	22.04	3
4	Licensed Practical Nurses	12,533	13,743	258,670	18.82	4
5	Nurse Aides & Orderlies	46,605	49,233	528,539	10.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,932	4,388	71,918	16.39	8
9	Activity Director	1,789	2,046	28,434	13.90	9
10	Activity Assistants	5,669	5,950	52,740	8.86	10
11	Social Service Workers	1,848	2,071	27,094	13.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,944	4,288	62,165	14.50	14
15	Cook Helpers/Assistants	12,749	13,569	104,047	7.67	15
16	Dishwashers					16
17	Maintenance Workers	4,432	4,783	58,133	12.15	17
18	Housekeepers	6,322	6,866	47,470	6.91	18
19	Laundry	4,974	5,149	36,024	7.00	19
20	Administrator	1,971	2,068	71,910	34.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,432	3,898	64,488	16.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,877	6,280	116,130	18.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,798	136,399	$ 1,827,125 *	$ 13.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	158	$ 7,053	1-3	35
36	Medical Director	24	3,600	9-3	36
37	Medical Records Consultant	40	1,900	10-3	37
38	Nurse Consultant	339	13,563	10-3	38
39	Pharmacist Consultant	12	936	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	9	526	11-3	44
45	Social Service Consultant	113	7,190	12-3	45
46	Other(specify) PSYCHO SOCIAL	15	828	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	710	$ 35,596		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	418	$ 13,405	10-3	50
51	Licensed Practical Nurses	967	29,240	10-3	51
52	Nurse Aides	2,011	39,330	10-3	52
53	TOTAL (lines 50 - 52)	3,396	$ 81,975		53

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARIE HARTZOG	ADMIN		$ 71,910
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,910

B. Administrative - Other

Description		Amount
FIRST HEALTH CARE	MANAGEMENT FEES	$ 329,195
TOTAL (agree to Schedule V, line 17, col. 3)		$ 329,195
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		112,168
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 112,168

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,918
Unemployment Compensation Insurance	33,039
FICA Taxes	130,389
Employee Health Insurance	113,823
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	6,173
EMPLOYEE PHYSICAL EXAMS	900
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 314,242

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,693
Health Care Worker Background Check	439
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	15,873
TRUST/FRANCHISE/CONTRIB/ETC	2,850
LICENSES & PERMITS	1,045
DUES & SUBSCRIPTIONS	1,299
MGMT CO ALLOCATION	813
TRUST/FRANCHISE/CONTRIB/ETC	(2,850)
Less: Public Relations Expense	(7,514)
Non-allowable advertising	(7,605)
Yellow page advertising	(754)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,289

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	4,512
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,512

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	6/2001	$ 1,577		$	$	$ 263	$ 525	$ 525	$ 264	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,577		$	$	$ 263	$ 525	$ 525	$ 264	$	$	$

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,495** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **45,990**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: MAPLE CREST CARE CENTRE **#0044172** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,053	
	REPAIRS & MAINTENANCE		785	
			0	7,838
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,070	
			0	1,070
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		19,952	
	ELECTRICITY		50,082	
	WATER		6,778	
	CABLE TV - LOBBY		939	
			0	77,751
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		16,300	
	PAINTING & DECORATING		345	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		15,607	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,919	
	FIRE SERVICE		1,018	
			0	
			0	
			0	35,189
7	**OTHER**			
	SCAVENGER		2,758	
	SECURITY SERVICE		185	2,943
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	3,600	3,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	81,975	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		3,112	
	PSYCHO-SOCIAL CONSULTANT	XVIII B 46-2	828	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,900	
	PHARMACY CONSULTANT	XVIII B 39-2	936	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	13,563	
			0	
			0	102,314
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		5,891	
	SPEECH THERAPY SERVICES		55	
	OCCUPATIONAL THERAPY SERVICES		7,183	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	13,129
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	526	
			0	526
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	7,190	
			0	7,190
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MAPLE CREST CARE CENTRE #0044172 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		50	50
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	329,195	329,195
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,435	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	96,733	
			0	112,168
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	7,514	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,605	
	EMPLOYEE WANT ADS	XIX F	6,693	
	CONTRIBUTIONS	VI 20 XIX F	1,100	
	DUES & SUBSCRIPTIONS	XIX F	1,299	
	LICENSES & PERMITS	XIX F	1,045	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	754	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,750	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	439	28,199
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,925	
	EQUIPMENT REPAIR & MAINTENANCE		701	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	66	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		145	
	TELEPHONE		11,546	
	MESSENGER SERVICE		35	
			0	14,418

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	130,389	
	UNEMPLOYMENT COMPENSATION	XIX D	33,039	
	WORKERS COMPENSATION INSURANC	XIX D	29,918	
	HOSPITALIZATION INSURANCE	XIX D	113,823	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,173	
	EMPLOYEE PHYSICAL EXAMS	XIX D	900	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	314,242
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,877	5,877
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,776	2,776
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		105,112	105,112
27	**OTHER**			
	BAD DEBTS	VI 24	24,000	
			0	24,000

GRAND TOTAL COLUMN 3 OTHER 1,187,587

MAPLE CREST CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	102,839	PATIENT MEALS	88272
LESS SALES TAX	(749)	ADD EMPLOYEE MEALS	0
NET FOOD	102,090	TOTAL MEALS/YEAR	88272
TOTAL PATIENT CENSUS	29,424	NET FOOD	102090
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	88272
TOTAL PATIENT MEALS	88272	COST PER MEAL	1.16
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

MAPLE CREST CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S										4,114,939	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		1,562,714	314,242	260,675	46,286	286,158	783,234	45,990	231,530		1,827,125
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	590		1,361			3,784		(5,735)		
	CABLE TV			(939)			939				
	CONTRACT NURSING										81,975
	INTEREST INCOME							(9,680)			
	NET VENDING COMMISSIONS							(3,034)			
	EMPLOYEE PHYSICAL EXAMS		(900)				900				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES						(329,195)		329,195		
	O2 INCOME/OTHER INCOME							(50)			
	BAD DEBTS						(24,000)	24,000			
	DISCOUNTS LOST							0			
	ANCILLARIES	264,778							0		
	SETTLEMENT INTEREST										
	RECLASSED SALARIES	0	0	0	0	0	0	0	0		
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	16,023	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS		1,828,082	313,342	261,097	46,286	286,158	435,662	73,249	554,990	3,798,866	1,909,100
PER FINANCIAL STATEMENTS		1,828,082	313,342	261,097	46,286	286,158	435,662	73,249	554,990	316,073	1,909,100
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										316,073	

MAPLE CREST CARE CENTRE - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		30,660			28596			2,064	28548		
CENSUS DAYS		29,424			27391			2,033	26846		
OCCUPANCY %		95.97%			95.79%				94.04%		
SALARIES											
TOTAL General Services	8-1	307,839	8.79%	10.46	314058	9.61%	11.47	(6,219)	316512	10.98%	11.79
Social Services	12-1	27,094	0.77%	0.92	26085	0.80%	0.95	1,009	24354	0.84%	0.91
TOTAL Health Care and Programs	16-1	1,382,888	39.47%	47.00	1176473	36.01%	42.95	206,415	1079083	37.42%	40.20
Clerical & General Office Expenses	21-1	64,488	1.84%	2.19	57470	1.76%	2.10	7,018	57320	1.99%	2.14
TOTAL General Administration	28-1	136,398	3.89%	4.64	120148	3.68%	4.39	16,250	115120	3.99%	4.29
TOTAL Operation Expense	29-1	1,827,125	52.15%	62.10	1610679	49.30%	58.80	216,446	1510715	52.39%	56.27
ADJUSTED TOTALS											
Food	2-8	102,090	2.91%	3.47	45720	1.40%	1.67	56,370	14899	0.52%	0.55
Heat and Other Utilities	5-8	77,751	2.22%	2.64	86711	2.65%	3.17	(8,960)	84463	2.93%	3.15
Maintenance	6-8	118,238	3.37%	4.02	124717	3.82%	4.55	(6,479)	123695	4.29%	4.61
TOTAL General Services	8-8	593,061	16.93%	20.16	565419	17.31%	20.64	27,642	546090	18.94%	20.34
Administrative	17-8	77,025	2.20%	2.62	66112	2.02%	2.41	10,913	62325	2.16%	2.32
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	114,301	3.26%	3.88	105148	3.22%	3.84	9,153	162914	5.65%	6.07
Fees, Subscriptions, Promotions	20-8	10,289	0.29%	0.35	11239	0.34%	0.41	(950)	11374	0.39%	0.42
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
License Fee-Other	Pg21	1,045	0.03%	0.04	1820	0.06%	0.07	(775)	752	0.03%	0.03
Clerical & General Office Expenses	21-8	189,163	5.40%	6.43	168674	5.16%	6.16	20,489	166374	5.77%	6.20
Employee Benefits & Payroll Taxes	22-8	314,242	8.97%	10.68	266905	8.17%	9.74	47,337	240845	8.35%	8.97
Payroll Taxes	Pg21	163,428	4.66%	5.55	150002	4.59%	5.48	13,426	143775	4.99%	5.36
W/C Insurance	Pg21	29,918	0.85%	1.02	29354	0.90%	1.07	564	27108	0.94%	1.01
Health Insurance	Pg21	113,823	3.25%	3.87	74428	2.28%	2.72	39,395	56333	1.95%	2.10
Inservice Training & Education	23-8	5,877	0.17%	0.20	4136	0.13%	0.15	1,741	6819	0.24%	0.25
Travel and Seminar	24-8	4,512	0.13%	0.15	5270	0.16%	0.19	(758)	5019	0.17%	0.19
Other Admin. Staff Transportation	25-8	2,776	0.08%	0.09	2616	0.08%	0.10	160	2950	0.10%	0.11
Insurance-Prop.Liab.Malpractice	26-8	107,740	3.07%	3.66	66828	2.05%	2.44	40,912	43983	1.53%	1.64
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
TOTAL General Administration	28-8	825,925	23.57%	28.07	696928	21.33%	25.44	128,997	702603	24.36%	26.17
TOTAL Operation Expense	29-8	2,995,655	85.49%	101.81	2828584	86.58%	103.27	167,071	2591149	89.85%	96.52
Real Estate Taxes	33-3	(4,526)	-0.13%	(0.15)	54310	1.66%	1.98	(58,836)	29930	1.04%	1.11
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	3,503,908	100.00%	**119.08**	3266942	100.00%	**119.27**	236,966	2883770	100.00%	**107.42**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1181147.1	33.71%	**40.14**	1067394.1	32.67%	**38.97**	113,753	1076660.7	37.34%	**40.11**

MAPLE CREST CARE CENTRE - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 525 from Page 22 and 0 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest expense on Page 4 Line 32-4 = Page 9 Line 15-10.
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-3072
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 = Page 14 Line 7-4.
#VALUE!
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.